<table>
<thead>
<tr>
<th>Agenda</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2017 Meeting Minutes</td>
<td>3</td>
</tr>
<tr>
<td>Lead Agency Report</td>
<td>6</td>
</tr>
<tr>
<td>“Coordinating Your Way Home in Houston” USICH Blog</td>
<td>9</td>
</tr>
<tr>
<td>“Houston Pilots Coordinated Entry for Survivors of Domestic Violence” USICH Blog</td>
<td>12</td>
</tr>
<tr>
<td>2017 NOFA Scoring Rubric</td>
<td>14</td>
</tr>
<tr>
<td>Memo: TH/PH-RRH</td>
<td>15</td>
</tr>
<tr>
<td>Policy on the Use of TH/PH-RRH Component in the 2017 HUD NOFA Competition</td>
<td>16</td>
</tr>
<tr>
<td>Memo: Income Now Public Workforce Intervention</td>
<td>17</td>
</tr>
<tr>
<td>Income Now Dashboard, May 2017</td>
<td>18</td>
</tr>
<tr>
<td>Workforce Solutions Referral Plan</td>
<td>20</td>
</tr>
</tbody>
</table>
AGENDA

• Call to Order – Daphne Lemelle
  a) Roll Call – Marilynn Kindell

• Approval of Minutes – Daphne Lemelle
  a) April 2017 CoC Steering Committee Meeting

• Lead Agency Report -- Add to official minutes
  a) USICH blogs (DV Coordinated Access and Coordinated Access)

• Old Business
  a) FY2017 NOFA – Eva Thibaudeau
     • Updated Scoring Tool
     • TH/PH-RRH Memo
     • TH/PH-RRH Re-allocation Policy (Resolution `5.2017)
  b) Income Now – Eva Thibaudeau
     • Update Memo
     • New process workflow
  c) Chronically Homeless Housing Initiative – Eva Thibaudeau

• New Business
  a) Meaningful Change campaign – Eva Thibaudeau

• Announcements
  a) Second Quarter Provider Input Forum is scheduled May 23, 2017 at 8410 Lantern Point

• Public Comments

• Adjournment
The Way Home

Steering Committee Meeting

April 13, 2017

Minutes

Present:

Tory Gunsolley (Houston Housing Authority), Marilynn Kindell (Ft Bend County Community Development), Daphne Lemelle (Harris County Community Services Dept.), Greg Pate (Provider Representative), Laura Marsh (Michael E. DeBakey, VA Medical Center), Ana Rausch (Lead Agency Staff), Dr. Joanne Ducharme (Montgomery County Community Development), Kelli King-Jackson (Simmons Foundation), Dr. Joanne Ducharme (Montgomery County Community Development), Kelli King-Jackson (Simmons Foundation), , Karl Erickson (Consumer Representative).

Absent:

Horace Allison (Harris County Housing Authority), Deiko Taylor (Consumer Representative), Heather Garza (City of Pasadena, Community Development), Tom McCasland (City of Houston Housing and Community Development Department) Mike Temple (Houston Galveston Area Council) Kim Kornmayer (The Harris Center) Gerald Eckert (Provider Representative).

The meeting of the Continuum of Care (CoC) Steering Committee was held on April 13, 2017 at 2000 Crawford St., Suite 700, pursuant to proper notification of all Steering Committee members.

Welcome and Introductions
Lemelle called the meeting to order at 3:35 pm. Kindell conducted roll call and noted there was a quorum.

Approval of Minutes
The minutes from the March CoC Steering Committee meeting were presented. Lemelle called for a motion to approve the February minutes as presented. Erickson motioned, King-Jackson seconded.

The minutes were approved.

Lead Agency Report
The Lead Agency Report was presented by Ana Rausch and added to the official minutes.

Old Business
• **FY2016 NOFA Scoring** - Scoring Tool was updated and offered for review. No questions were asked.

• **RRH** – Lamelle asked for dashboard. Sara Brown agreed to print and make available online. Orientation for Young Adult RRH and Singles RRH occurring. Family RRH in operations. Two years of RRH produced data for program evaluation.

• **Chronic Homeless Housing Initiative** – Navigation event for chronic homeless held at BEACON on March 28th. 200 chronic homeless persons invited and 80 were served. Next one will be in May.

• **Coordinated Access** – Updated scoring tool matches score with housing intervention.

• **Income Now TWC Extension** – State funding ends on April 30, 2017. Transition to Workforce occurring. Referrals from CA will continue in the next phase and be directed to Workforce.

New Business

• **Housing Choice Vouchers** – Discussion of voucher usage.

• **City of Houston Ordinances** – Two ordinances past at City of Houston. First, address panhandling making it illegal to block roads and doorways. Second is anti-encampment ordinance deterring camping and limits person belongings to three cubic feet? City has been partner in The Way Home. Coalition communications department has been handling media requests focusing on permanent housing solutions under The Way Home.

• **FY2017 NOFA Projections** – It was noted that HUD has have working really hard to catch up the last 4 years because they were 2 years behind. Their intention is to release in May, with an August due date. December release of awards.

Announcements
Second Quarter Provider Input Forum, May 23 from 9:00am-10:30am at 8410 Lantern Point.

Public Comments
No public comments

Adjournment
Upon approval, the meeting was adjourned at 4:09 pm.

Respectfully Submitted,                        Approved,

________________________                        __________________________
Marilynn Kindell, Secretary

_____________________
Date

Daphne Lemelle, Chairman

_____________________
Date
A. Networks, Initiatives and Affinity Groups
   a. CoC Provider Input Forum
      i. The Second Quarter Provider Input Forum is scheduled Tuesday May 23, 2017 at 8410 Lantern Point and will include a review of the disaster communications plan.
   b. CoC Consumer Input Forum
      i. The Spring Consumer Input Forum was conducted in April comprised of four focus groups on evaluating the Income Now initiative. Groups convened on April 7, 27, and 28. The focus group data is expected to be presented at the June Steering Committee meeting.
   c. Housing Houston’s Heroes
      i. The SSVF workgroup meets the second Thursday Monthly from 11am-12:30pm.
      ii. The 2017 SSVF CoC Plan update and survey was submitted on April 25, 2017. Further the SSVF workgroup convened on May 4th to evaluate the VA Homeless Prevention scoring tool and confirm the threshold with the VA.
   d. Youth/Young Adult Workgroup Group
      i. Coalition for the Homeless conducted a YYA Workgroup for all CoC youth providers.
   e. RRH Workgroup
      i. The RRH Expansion Workgroup meets twice a month. The Project Manager conducts a monthly staffing with each team and facilities a Peer Group for the Case Managers.
      ii. The FAI/CMI meeting is conducted Tuesdays from 11:30 to 12:30 pm.
      iii. The ESG Funders workgroup meets monthly and is comprised of Cities of Houston and Pasadena, Counties of Fort Bend and Harris and the CoC Lead Agency representing the CoC.
      iv. The YA RRH workgroup orientation was on April 18, 2017. Referrals for the program have begun and workgroup is meeting weekly.
      v. The Singles RRH workgroup began implementation and started taking referrals.
   f. HMIS & Coordinated Access
      i. The Coordinated Access workgroup continues to meet as needed.
      ii. The Permanent Supportive Housing Workgroup meets as needed.
      iii. New APR changes became effective on April 1, 2017. HUD is now requiring that APRs be uploaded into Sage, a new online database. The Coalition’s HMIS Team attended training on how this will affect providers.
      iv. At the NHSDC Conference, the Coalition’s HMIS Team attended a meeting with Eccovia, the Client Track provider. System performance reporting & APR changes were reviewed.
      v. Continued planning for expanding Coordinated Access into Fort Bend is underway.
g. Income Now Workgroups
   i. The Income Now Implementation Workgroup meets weekly on Tuesdays from 2:30pm to 4:00pm at SEARCH. The meeting rotates weekly between full implementations team and supervisors’ meeting.
   ii. The SOAR Workgroup meets bi-monthly and will convene on June 22nd with expansion of members to include Montgomery County and Fort Bend County providers.
   iii. The SOAR transition team meets bi-weekly to monitor and implement Coordinate Access work flow.
   iv. The Income Now Workforce Transition team meets weekly on Tuesdays from 11:30 AM to 12:30 PM.
   v. Four consumer focus groups have been conducted as the Consumer Input Forum in April to evaluate the Income Now initiative. Researcher, Dr. Cathy Troisi, facilitated the focus groups and will deliver a report to the CoC Steering Committee by the June meeting. The data from the focus groups will be used to create a satisfaction and outcomes survey targeted for wide distribution to all clients referred to Income Now.
   vi. The Income Now TWC state grant ended on April 30th, 2017. Approximately twenty participants were approved to continue with OJT through May 26. Income Now workflow is transitioning to all WFS career offices in the CoC with direct HMIS referrals through the Coordinated Access system starting on May 15, 2017. Income Now staff will be maintained at the current four homeless shelter locations as WFS satellite offices.

h. CoC Regional Workgroups – The CoC regional team meets weekly from 10:30 to 12:00 on Wednesdays.
   i. Fort Bend County--Project Manager Amber Paaso
      1. Visited Fort Bend County Social Services and Salvation Army completing 6 homeless assessments resulting in one referral to PSH, four referrals to RRH and one referral to Income Now.
      2. Collaborated with SSVF Career & Recovery Outreach to house Vietnam Veteran living on the streets for 3 decades. The client is now housed.
      3. Assisted with and attended Case Managers Resource Exchange hosted by Interfaith of The Woodlands regarding the CoC regional team action plan.
      4. Continued attendance at monthly meetings including local city councils, Fort Bend Chamber Network Nites, and Fort Bend Commissioners Court Meetings, Fort Bend Connect and Fort Bend Veterans Association.
      5. Held collaborative meeting with Fort Bend Behavioral Health Services to assess needs for homeless services through coordinated access.
      6. Met with Fort Bend County Community Development partners to discuss RRH and PSH in Fort Bend.
      7. Attended Fort Bend County Collaborative Information Network Meeting hosted by Fort Bend Social Services.
      8. The Coalition will co-host the Homeless Network meeting on May 19th at United Way Fort Bend Center. Homeless Prevention assessment and workgroup development for the CoC will be the main focus.
   ii. Montgomery County--Project Manager Nancy Heintz
      1. The Montgomery County Homeless Coalition meets monthly at Conroe Chamber of Commerce on the 3rd Thursday. The Project Manager
maintains a standing agenda item to provide updates about the work of The Way Home CoC and the Coalition at the monthly meeting.

2. Hosted the Quarterly Case Managers Resource Exchange at Interfaith in The Woodlands. Spotlighted VOA in Montgomery County and the work of the CoC regional project management team.

3. Attended the Montgomery County Housing Authority Board meeting on April 12.

4. Provided assessment assistance at the VA outreach clinic (RRH/SSVF), VOA (PSH), and Crises Assistance Center (PSH).

5. Attended the Workforce Development Committee meeting at the Conroe Chamber of Commerce.

B. Other CoC Items

a. The SOAR workgroup was featured in two articles national distributed by SOARworks including a success story on successfully housing a chronically homeless gentleman and obtaining approved SSI/Medicaid benefits within five weeks.

b. The Downtown Transition meetings are now occurring as needed.

c. The Workgroup on Ending Chronic Homelessness began meeting weekly with all PSH providers and system CA Navigators. The purpose is to decrease the length of time from referral to PSH enrollment. This will continue the Mayor’s Challenge to house 500 clients by September 2017.

d. Three HMIS staff from the Coalition attended the National Human Services Data Consortium in Salt Lake City the last week of April 2017. Ana Rausch presented during two conference sessions: 1) Prioritization: Targeting Households & Coordinated Resources for the Most Successful Outcome and 2) Connecting the Dots: Technology and Coordinated Access to Enhance Your PIT.

e. The Landlord Marketing Workgroup is working to identify new properties to participate in The Way Home programs. The group is targeting companies with large portfolios, class C & D, and with occupancy issues (vacancy rates of 12% or higher). The group is also planning a legal seminar for July, to be hosted and sponsored by the Houston Apartment Association.
Coordinating Your Way Home in Houston

You know that “butterflies in your stomach” feeling when you speak in front of a large group of people? That’s how I felt for most of 2013-14 as we implemented coordinated entry (or as we call it in Houston, “Coordinated Access”) for the TX-700 Continuum of Care (CoC).

But let me back up: The work to build Coordinated Access in Houston began in 2012 as part of a community-wide system redesign process. At that time, we redesigned our governance structure, built models of accountability and full transparency, and conducted an analysis of our resources and housing inventory.

Then HUD issued a notice for coordinated entry deadlines and requirements, so the Coalition for the Homeless (lead agency to the CoC known here as “The Way Home”) brought together a Coordinated Access workgroup to develop the system in Houston and the rest of The Way Home’s vast geography, which at the time covered more than 2,600 square miles and three counties - Harris, Fort Bend, and Montgomery.

The Coordinated Access workgroup developed a standardized housing assessment tool to determine the best housing for an individual or household. We focused first on Permanent Supportive Housing (PSH), since new PSH units would be coming online during the roll-out of Coordinated Access. Emergency shelter and transitional housing were not incorporated into Coordinated Access because we don’t have a large shelter bed inventory, most shelter beds are privately funded, and our system was in the process of reallocating transitional housing funds to permanent housing.

Once we agreed on an assessment tool, we worked with our HMIS software provider to incorporate the assessment into HMIS and develop a system that would integrate a housing match and wait list. That way, after an assessment was completed, the Housing Assessor would be able to see in HMIS if a client was eligible for a PSH intervention and what programs and units they matched. The system would also show which programs had real-time availability. In cases where there was not availability, the client would be placed on one community-wide waitlist for PSH.
At the same time, a PSH workgroup convened to standardize the intake documents for all PSH providers within The Way Home, and to determine how to prioritize within the waitlist. All PSH units in The Way Home are dedicated to individuals or households that are experiencing chronic homelessness. The Vulnerability Index™ (VI) assessment was used to further prioritize the most vulnerable clients on the PSH waitlist. The VI scores range from 0-8 (8 is the highest vulnerability) and the HMIS automatically sorts the waitlist by VI score, with the most vulnerable client being referred first.

The next issue to tackle was staffing. I was the only paid staff assigned to Coordinated Access implementation, and there was no other funding available to hire new staff. With some creative thinking, we asked our partner agencies if they would be willing to repurpose some of their existing staff to work on behalf of the system. A CoC-funded Supportive Services Only grant was repurposed to pay for our first two Coordinated Access Navigators. Additionally, other intake staff funded by state, city, and county Emergency Solutions Grants and other private funds were repurposed to pay for our first Coordinated Access Assessors.

It was a challenge to convince our partners to essentially pay for their staff to do the same job, but for the whole system, but we pointed out that the outcomes for their grants would still be met. To this day, our Coordinated Access staffing mechanism remains one of the greatest homelessness system transformations that our community has ever seen.

With these pieces in place, and existing PSH waitlists in the system, we rolled out Coordinated Access in January 2014. Due to the vastness of The Way Home’s geography, we opted for a coordinated system versus a centralized system. This included multiple access points at emergency and day shelters, and Coordinated Access-staffed outreach teams. Our physical Coordinated Access Hubs were set up where clients were already accessing services—at the VA Drop-in Center, all family and single shelters in downtown Houston, and the day program. Other hubs are located outside the city in social service agencies. We’ve integrated Medicaid providers, hospital emergency departments, and programs that serve those exiting jails or prisons. Houston has also recently implemented a telephonic intake assessment that is available to providers to call with the client present.

Coordinated Access is managed entirely within HMIS, and no matter which hub a person goes to, the process is the same. People in need of a housing assessment meet with an Assessor who uses the assessment tool to determine the best housing intervention. This is followed by the VI Assessment to determine the client’s vulnerability score.

Based on the assessment, HMIS automatically matches clients with programs for which they are eligible, and they can always choose among programs that they want. The Assessor and client review the list. Although we have one community-wide waitlist for PSH, clients can always indicate a preference for a particular program or programs and/or a particular agency. If no units are available, the client is placed on the one waitlist with a noted preference for a specific program. The vulnerability score determines when the client will be referred. If units are available and the client is next on the waitlist, a referral is made to a program in real time. Previous experience had shown us that people experiencing chronic homelessness often get lost from referral to move-in, so they are partnered with a Navigator who supports them through the move-in process. Once moved in, the client and Navigator meet with the PSH case manager for a warm hand-off.
Our CA system is a living, breathing system that focuses on continuous improvement. Since the roll out, we have added programs like rapid re-housing, and we have developed new, local prioritization tools for youth, families, and non-chronically homeless singles. We have added 10 hubs, and we updated our assessment to include an income intervention to go along with a client’s housing intervention, when the assessment indicates a need. We are also looking at our assessment and prioritization tools as our population demographics change.

There have been some bumps in the road, but Coordinated Access has proven to be more effective and efficient than the old way of doing things—we are all united behind a common goal. The unprecedented collaboration of The Way Home partners has helped change the path toward ending homelessness for our community, and it is something that we are all incredibly proud of.

posted in:
Setting a Path to End All Homelessness
Houston Pilots Coordinated Entry for Survivors of Intimate Partner Violence

In Harris County, TX, our providers connect more than 5,500 people to domestic violence emergency shelter every year, and we receive nearly 80,000 calls to our domestic violence hotlines. Our resources fall far short of the demand: we are turning away, on average, 30 to 40% of victims fleeing domestic violence who are trying to access emergency shelter and ultimately move on to a permanent home.

We knew we could do better to make sure we were using our resources the most efficiently and effectively and tailoring our housing and services to meet people’s specific needs. Through a partnership between the Harris County Domestic Violence Coordinating Council and the Houston Coalition for the Homeless, we decided to explore two pilot projects to test the effectiveness of coordinated access among our domestic violence service providers using an assessment tool for connecting victims to the housing and services they need.

Working with our area’s five victim service providers and the Coalition, we agreed that our key priorities were to develop a coordinated access system, create a way to prioritize services based on need and safety, and gather collective data to help define the community’s need for safe housing and services options for survivors of domestic violence. Early in the process, confidentiality issues created barriers and challenges for the group to consider. We had many discussions about how to function as a domestic violence system while maintaining confidentiality and adherence to VAWA legislation.

As we navigated those challenges, the Coalition offered the funding to support a project manager who guided us in developing a coordinated access system, which kept agencies invested in advancing the work and facilitated a relationship that solidified the commitment to work across sectors. The group found common ground in needing a coordinated approach to housing, needing to collect data and evidence, and needing to have a system for prioritizing those with the highest needs for the limited domestic violence-specific housing options.

Our first pilot, which has been operating for around 6 months now, uses a decentralized coordinated access process. For triage and prioritization into housing, our five providers use the EPPA tool (Eligibility, Prioritization, and Placement Assessment), which was developed by the workgroup and informed by the work of Dr. Jacqueline Campbell’s Danger Assessment. The EPPA tool includes an enhanced lethality assessment to create the core element of the prioritization score. The overall score places clients on a waitlist based on their need for DV-specific housing.

Creating scores, prioritizations, and a waitlist are without a doubt the heaviest pieces to manage in the pilot. The providers on the front line have told us that while a waitlist doesn’t provide an immediate solution for everyone, it does expand the options providers have. While the assessment is not perfect, we believe that it has been a good place to start and we’re continuing to evaluate the scores and assessments.
Our second pilot, which has been operating for a little more than 3 months, is structured to focus on diverting individuals and families from shelter into rapid re-housing. Because of the management burden of a decentralized access process, we decided to test this model using a centralized system. Survivors of domestic violence who are not yet in shelter can call a central hotline and be assessed using the EPPA tool for rapid re-housing.

It’s important to note that each pilot has a core group of providers who can refer a survivor into another project if safety is or becomes a concern. Survivors are enrolled into the DV coordinated access system, but may also elect to self-refer into coordinated access for the homelessness service system. In addition, domestic violence providers may refer clients with their permission into coordinated access.

While both of our pilots are still new, our group has fought for some lessons learned along the way:

- Having money and resources to support the process keeps agencies at the table.
- Collaboration requires trust, time, and the willingness to release control.
- Taking the time for debate and getting all involved from the beginning is crucial to the long-term success.
- Don’t avoid the difficult conversations. They’re further indication that they need to happen.

As we continue to implement our pilots, we already know some of the work ahead, including:

- Developing better solutions to address confidentiality without creating systemic barriers for access to housing
- Finding better ways to maximize resources while meeting the complex needs of families, including removing systemic barriers and funding requirements that create additional barriers
- Creating a smooth and efficient process for survivors working with homelessness providers to access non-residential services from DV providers
- Capitalizing on the expertise that homelessness and DV service providers have created throughout the years to support each other in serving survivors in a true client-centered approach based on what they identify as their immediate need

This work isn’t easy. But through these pilots we’re creating a space to have some really hard conversations as a community about how to streamline our processes so that survivors can get the housing and services they need as quickly as possible. It’s our hope that our lessons can help you create something even better!

posted in: Families
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** If agencies fall under DV category, points automatically given, due to current planning for pending implementation.

** Includes any due date throughout the competition.

* If agencies are not funded based on Units, the default will be bed Utilization Rate.
This Memorandum is to inform The Way Home Continuum of Care Steering Committee about the HUD proposed TH/PH-RRH activity in the upcoming CoC NOFA.

Background:

In the FY2017 CoC NOFA Registration, HUD let CoC’s know that a new component type may be eligible for re-allocation funding in the upcoming CoC Program NOFA. The name of this new component is TH/PH-RRH. The intent is the allow utilization of existing brick and mortar facilities that cannot be used as PH and thus have been lost to CoC housing inventory. HUD is modeling the TH part of this component on VA “bridge beds” that can provide short-term, non-programmatic housing to persons awaiting permanent housing availability.

More information regarding this permanent housing component will be available in the CoC Program NOFA (sometime post June 9th). In an effort to prepare our remaining TH partners, a call/meeting was conducted to share the limited information available. TH partners were notified that a policy would be presented to the CoC Steering Committee at the May 2017 meeting that would allow them to re-apply for this new component type at their previous funding level. Funding would be contingent on multiple factors including:

- CoC compliance
- Regulatory and fiscal compliance
- Agreement to function as bridge housing which means acting as low-barrier, short-term housing with the focus on preparing residents for the responsibilities of tenancy
Policy on the Use of TH/PH-RRH Component in the 2017 HUD NOFA Competition

The Houston, Pasadena, Conroe/Harris, Fort Bend, Montgomery Counties Continuum of Care (TX-700) will accept joint Transitional Housing/Permanent Housing-Rapid Rehousing Projects from eligible applicants in the 2017 HUD Continuum of Care NOFA application cycle.

- **Eligible applicants for Joint TH/PH-RRH projects include:**
  - Organizations that are eligible recipients of funding under 24 CFR 578 HUD Continuum of Care Program.
  - The CoC does not intend to increase the inventory of transitional housing. In the 2017 NOFA competition, the TH/PH-RRH option is only available to current grantees providing transitional housing services.

- **Program requirements:**
  - All referrals and program enrollments will be done through the Coordinated Access process within The Way Home CoC.
  - All housing provided must meet Housing First standards: there are no sobriety, income, or criminal background requirements other than those essential for the health and well-being of all project participants.
  - The length of stay in transitional housing will be the minimum necessary to place the household in permanent housing.
  - Grantees must assist participants in becoming ‘document ready’ for housing placement.
  - During the time in transitional housing and while in rapid rehousing, the grantee will support the participants in understanding and complying with their obligations of tenancy
  - Grantees must assist the participant to locate and secure permanent housing and then provide rental assistance and supportive services to support housing stability.
  - Rental assistance will be provided consistent with the CoC standards for assistance under Rapid Rehousing. The assistance shall be the minimum necessary to prevent a return to homelessness and shall not be provided for a period in excess of 24 months.

- **Eligible funding:**
  - Operating or leasing costs to support the transitional housing costs. Expenses must be eligible under 24 CFR 578.49 (Leasing) or 578.55 (Operating Costs)
  - Tenant based rental assistance administered consistent with 578.51 (rental assistance) is the only allowable form of housing assistance for those receiving rapid rehousing
  - All participants in transitional housing or rapid rehousing are eligible to receive supportive services as provided under 24 CFR 578.53.
  - Administrative costs of up to 10% may be requested.
SUBJECT: Income Now Public Workforce Intervention  
DATE: 5/11/2017

This Memorandum is to inform The Way Home Continuum of Care Steering Committee about the current status of the Income Now Public Workforce Intervention

Background:

The Income Now initiative was launched at the beginning of 2016 with three income types identified: SOAR, Supported Employment, and Public Workforce. With regard to the public workforce intervention, Texas Workforce Commission funded an initial 15 month grant that implemented workforce services through a five agency collaborative. The original contract was scheduled to end on October 31, 2016; but, was extended for an additional period of six months through April 30th 2017. A second extension was requested in March 2017 but not approved. The TWC grant term effectively ended on April 30, 2017 with services in Paid Work Experience continuing through May 26 for twenty clients who were already enrolled in the ten week PWE term until its completion. Below is a summary of the transition plan for the Public Workforce System

- As of May 15, 2017 all referrals from Coordinated Access to Income Now public Workforce will be delivered directly to a Workforce Solutions career office throughout the CoC determined by client choice. This includes four satellite Workforce Solutions offices co-located at major shelter hubs including; Covenant House, Star of Hope Women’s and Family, Star of Hope Men’s Development Center, and Salvation Army Harbor Light
- The TWC grant close out is scheduled for sixty days ending on June 29. 2017. Outcome data will continue to be collected during close out with a final outcome report being delivered by June 29, 2017
- At this time, 651 jobs have been secured, 516 clients employed in any job category, and 478 clients secured permanent work. It is anticipated that these numbers will increase during the close out period as pending jobs are verified.
- The average wage per client is $10.23
- See Income Now May Dashboard and Workforce Solutions Referral Chart attached
Income Now Dashboard - May 2017
HMIS data through May 9, 2017

Clients Referred: 1674
Clients Enrolled: 1188
Clients Exited: 795

Overall Job Placements: 651
Clients Employed: 516
Clients Permanently Employed: 478
Clients in Paid OJT: 205
Average Wage: $ 10.23

Note: Summary data is unduplicated. Detailed data may be duplicated across categories.

Income Now Referrals and Enrollments

Referrals to Provider

Enrollments by Organization

Placements by Job Classification
Permanent Job Placements by Organization
Includes: Full-time Permanent, Part-time Permanent, and Self-Employed

<table>
<thead>
<tr>
<th>Organization</th>
<th>Permanent Job Placements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avenue 360 Health &amp; Wellness</td>
<td>60</td>
</tr>
<tr>
<td>BakerRipley/WFS</td>
<td>63</td>
</tr>
<tr>
<td>Career and Recovery Resources</td>
<td>72</td>
</tr>
<tr>
<td>SEARCH Homeless Services</td>
<td>283</td>
</tr>
</tbody>
</table>

Average Wage by Organization

- Avenue 360 Health & Wellness: $9.76
- BakerRipley/WFS: $9.77
- Career and Recovery Resources: $10.50
- SEARCH Homeless Services: $10.33
Customer Workflow

Customer is assessed at CA in HMIS → Matched to WFS (all offices in CoC including the shelters) in HMIS → Referral “voucher” provided to the potential customer → Customer shows up at WFS Office or shelter satellite

Staff, Data, and Reporting Workflow

HMIS Assessment → HMIS Match → Report of referrals sent to WFS Tracking Team → WFS Tracking Team adds a flag to all people on the referral report

WFS runs a report monthly on all flagged customers that have received a service at a WFS office → WFS sends matched customers (in the past month) to CFTH → CFTH updates HMIS referral as “Accepted”

WFS sends unmatched customers (in the past 6 months) to CFTH → CFTH updates HMIS referral as “No Show”